EOHHS Technical Specifications Manual (1.3)

Appendix A-14

Subsection 3:
Pediatric Asthma Measures
(CAC-1a, CAC-2a)
Data Dictionary

Pediatric Asthma Measures (CAC-1a and CAC-2a)
Data Dictionary
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Data Element Name: *Admission Date*

Collected For: All MassHealth Records

Definition: The month, day, and year of admission for inpatient care.

Suggested Data Collection Question: Admission Date

Format:
Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000 – 9999)

Notes for Abstraction: Because this data element is critical in determining the population for all measures, the abstractor should **not** assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct admission date through chart review, she/he should default to the admission date on the claim information.

A patient of a hospital is considered an inpatient upon issuance of written doctors orders to that effect.

Suggested Data Sources:
Emergency department record
Face sheet
History and physical
Nursing admission assessment
Physician orders

Guidelines for Abstraction:

Inclusion	Exclusion
None	Admit to observation Arrival date

Data Element Name: *Admission Source*

Collected For: All MassHealth Records

Definition: The source of inpatient admission for the patient.

Suggested Data Collection Question: Admission Source

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 **Physician referral**
The patient was admitted to this facility upon recommendation of his or her personal physician,
or
Normal Delivery (if Admission Type = 4)
A baby delivered without complications.

2 **Clinic referral**
The patient was admitted to this facility upon recommendation of this facility's clinic physician,
or
Premature Delivery (if Admission Type = 4)
A baby delivered with time and/or weight factors qualifying it for premature status.

3 **HMO referral**
The patient was admitted to this facility upon recommendation of a health maintenance organization physician,
or
Sick baby (if Admission Type = 4)
A baby delivered with medical complications, other than those relating to premature status.

4 **Transfer From a hospital (Different Facility*)**
The patient was admitted to this facility as a hospital transfer from a different acute care facility where he or she was an inpatient,
or
Extramural Birth (if Admission Type = 4)
A newborn born in a non-sterile environment.
* For transfers from Hospital Inpatient in the Same Facility (see Code D).

Allowable Values continued:

5 **Transfer from Skilled Nursing Facility**
The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was an inpatient.

6 **Transfer from Another Health Care Facility**
The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long term care facilities and skilled nursing facility patients that are at a non-skilled level of care.

7 **Emergency Room**
The patient was admitted to this facility upon recommendation of this facility's emergency room physician.

8 **Court/Law Enforcement**
The patient was admitted to this facility upon the direction of a court of law or upon the request of a law enforcement agency representative.

9 **Information Not Available**
The means by which the patient was admitted to this hospital is not known.

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the admission source is correct. If the abstractor determines through chart review that the admission source is incorrect, she/he should correct and override the downloaded value.

If unable to determine admission source, select “9.”

Suggested Data Sources:
Emergency department record
Face sheet
History and physical
Nursing admission notes
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	If the patient was transferred from an emergency department of another hospital, do not use "7." This is only for patients admitted upon recommendation of **this** facility's emergency department physician/advanced practice nurse/physician assistant (physician/APN/PA).

Data Element Name: *Age at Discharge*

Collected For: CAC-1a, CAC-2a

Definition: The patient's age at the time of discharge.

Suggested Data Collection Question: At the time of discharge was the patient's age 2 years through 17 years?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	The patient's age was 2 years through 17 years at the time of discharge.
N (No)	The patient's age was not 2 years through 17 years at the time of discharge.

Notes for Abstraction: The patient's age (in years) at discharge can be calculated by *Discharge Date* minus *Birthdate*.

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Asthma Diagnosis Code*

Collected For: CAC-1a, CAC-2a

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code associated with asthma that makes this record eligible for the CAC-1 and CAC-2 measures.

Suggested Data Collection Question: What is the ICD-9-CM principal diagnosis code for asthma assigned to this record?

Format:
Length: 6 (implied decimal point)
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid ICD-9-CM diagnosis code in Appendix A, Table 6.1 in the Specifications Manual for National Hospital Quality Measures

Notes for Abstraction: The asthma diagnosis code must be identified as the principal procedure for the admission.

Suggested Data Sources: Discharge summary

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix A, Table 6.1 in the Specifications Manual for National Hospital Quality Measures for a list of valid ICD-9-CM codes.	None

Data Element Name: *Birthdate*

Collected For: All MassHealth Records

Definition: The month, day, and year the patient was born.

NOTE: Patient's age (in years) is calculated by *Admission Date* minus *Birthdate.* The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age**.**

Suggested Data Collection Question: Birthdate

Format:

Length:	10 – MM-DD-YYYY (includes dashes)
Type:	Date
Occurs:	1

Allowable Values:

MM =	Month (01-12)
DD =	Day (01-31)
YYYY =	Year (1880 – 9999)

Notes for Abstraction: Because this data element is critical in determining the population for all measures, the abstractor should **not** assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources: Emergency department record
Face sheet
Registration form

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *CAC Measure Eligibility*

Collected For: CAC-1a, CAC-2a

Definition: The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." For the CAC measures set, a valid asthma code should be identified as the principal diagnosis code.

Suggested Data Collection Question: Was there an ICD-9-CM principal diagnosis code of Asthma?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	The patient's principal diagnosis code is a valid asthma ICD-9-CM code.
N (No)	The patient's principal diagnosis code is not a valid asthma ICD-9-CM code.

Notes for Abstraction: None

Suggested Data Sources: Discharge summary

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix A, Table 6.1 in the Specifications Manual for National Hospital Quality Measures for a list of valid ICD-9-CM codes.	None

Data Element Name: *Case Identifier*

Collected For: All MassHealth Records

Definition: A measurement system-generated number that uniquely identifies an episode of care. This identification number should be used by the performance measurement system in order to allow the health care organization to link this Case Identifier to a specific episode of care.

Suggested Data Collection Question: What is the unique measurement system-generated number that identifies this episode of care?

Format:
Length: 9
Type: Numeric
Occurs: 1

Allowable Values: Values greater than 0 assigned by the system.

Notes for Abstraction: None

Suggested Data Sources: Unique measurement system generated number

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Clinical Trial*

Collected For: All MassHealth Records

Definition: Documentation that the patient was involved in a clinical trial during this hospital stay, relevant to the measure set for this admission. Clinical trials are organized studies to provide large bodies of clinical data for strategically valid evaluation or treatment. These studies are usually rigorously controlled tests of new drugs, invasive medical devices, or therapies on human subjects.

Suggested Data Collection Question: Is the patient participating in a clinical trial?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the patient was involved in a clinical trial during this hospital stay relevant to the measure set for this admission.
N (No)	There is no documentation that the patient was involved in a clinical trial during this hospital stay relevant to the measure set for this admission, or unable to determine from medical record documentation.

Notes for Abstraction: This data element is used to exclude patients that are involved in a clinical trial during this hospital stay relevant to the measure set for this admission. Consider the patient involved in a clinical trail if documentation indicates:

- The patient was evaluated for enrollment in a clinical trial after hospital arrival, but was not accepted or refused participation.
- The patient was newly enrolled in a clinical trial during the hospital stay.
- The patient was enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during the hospital stay.
- To answer "Yes" to this data element, there must be formal documentation (trial protocol or patient consent form) in the medical record that the patient was involved in a clinical trial

Notes for Abstraction continued:

designed to enroll patients with the condition specified in the applicable measure set.

- If it is not clear which study that the clinical trial is enrolling, select "No". Assumptions should not be made if it is not specified.

Suggested Data Sources: **ONLY ACCEPTABLE SOURCES:**

- Clinical trial protocol
- Consent forms for clinical trial

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Contraindication to Relievers*

Collected For: CAC-1a

Definition: Documentation of contraindications/reasons for not prescribing reliever medications during this hospitalization.

Relievers are medications that relax the bands of muscle surrounding the airways and are used to quickly alleviate bronchoconstriction and prevent exercise-induced bronchospasm. Relievers are also known as rescue, quick-relief, or short acting medications of choice to quickly relieve asthma exacerbations.

Suggested Data Collection Question: Is there documentation of contraindications/reasons for not prescribing relievers during this hospitalization?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation of contraindications/reasons for not prescribing relievers during this hospitalization.
N (No)	There is no documentation of contraindications/reasons for not prescribing relievers during this hospitalization or unable to determine from medical record documentation.

Notes for Abstraction: When there is documentation of an “allergy”, “sensitivity”, “intolerance”, “adverse or side effects”, cardiac dysrhythmias, etc., regard this as documentation of contraindication regardless of what type of reaction might be noted. Do not attempt to distinguish between true allergies, sensitivities, intolerances, adverse or side effects, cardiac dysrhythmias, etc. (e.g., “Allergies: Alupent – select “Yes.”)

Suggested Data Sources:
Consultation notes
Discharge summary
Emergency department record
History and physical
Medication administration record (MAR)
Nursing notes
Physician orders
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
Allergies/sensitivities/intolerance Cardiovascular side effects Cardiac dysrhythmias or arrhythmias Side effects Refer to Appendix C, Table 6.2 in the Specifications Manual for National Hospital Quality Measures for a comprehensive list of Reliever Medications	None

Data Element Name: *Contraindication to Systemic Corticosteroids*

Collected For: CAC-2a

Definition: Contraindications/reasons for not prescribing oral or intravenous (systemic) corticosteroids for asthma exacerbation during this hospitalization.

Corticosteroids are a family of potent anti-inflammatory medications produced either naturally by the adrenal cortex or manufactured synthetically, in inhaled, topical, oral, and intravenous forms.

Suggested Data Collection Question: Is there documentation of contraindications/reasons for not prescribing oral or intravenous corticosteroids during this hospitalization?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation of contraindications/reasons for not prescribing oral or intravenous corticosteroids during this hospitalization.
N (No)	There is no documentation of contraindications/reasons for not prescribing oral or intravenous corticosteroids during this hospitalization or unable to determine from the medical record documentation.

Notes for Abstraction: When there is documentation of an "allergy", "sensitivity", "intolerance", "adverse or side effects", regard this as documentation of contraindication regardless of what type of reaction might be noted. Do not attempt to distinguish between true allergies, sensitivities, intolerances, adverse or side effects, etc. (e.g., "Allergies: Prednisolone – select "Yes.")

Suggested Data Sources:
Consultation notes
Discharge summary
Emergency department record
History and physical
Medication administration record (MAR)

Suggested Data Sources continued:
Nursing notes
Physician orders
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
Allergies/sensitivities/intolerance Side effects Refer to Appendix C, Table 6.3 in the Specifications Manual for National Hospital Quality Measures for a list of Systemic Corticosteroids.	None

Data Element Name: *DHCFP Ethnicity*

Collected For: All MassHealth Records

Definition: Documentation of the patient's ethnicity as defined by the Massachusetts DHCFP regulations.

Suggested Data Collection Question: Ethnicity Code

Format:
Length: 6
Type: Alphanumeric
Occurs: 1

Allowable Values: Select one:

2060-2	African	**2039-6**	Japanese
2058-6	African American	**2040-4**	Korean
AMERCN	American	**2041-2**	Laotian
2028-9	Asian	**2148-5**	Mexican, Mexican American, Chicano
2029-7	Asian Indian	**2118-8**	Middle Eastern
BRAZIL	Brazilian	**PORTUG**	Portuguese
2033-9	Cambodian	**2180-8**	Puerto Rican
CVERDN	Cape Verdean	**RUSSIA**	Russian
CARIBI	Caribbean Island	**2161-8**	Salvadoran
2034-7	Chinese	**2047-9**	Vietnamese
2169-1	Columbian	**2155-0**	Central American (not specified)
2182-4	Cuban	**2165-9**	South American (not specified)
2184-0	Dominican	**OTHER**	Other Ethnicity
EASTEU	Eastern European	**UNKNOW**	Unknown/not specified
2108-9	European		
2036-2	Filipino		
2157-6	Guatemalan		
2071-9	Haitian		
2158-4	Honduran		

Notes for Abstraction: The data elements, *Hispanic Ethnicity* and *DHCFP Race* are required in addition to this data element. If numeric code is used, include the hyphen after the fourth number.

Suggested Data Sources:
Emergency department record
Face sheet
History and physical
Nursing admission assessment
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *DHCFP Race*

Collected For: All MassHealth Records

Definition: Documentation of the patient's race as defined by the Massachusetts DHCFP regulations.

Suggested Data Collection Question: Race

Format:
Length: 6
Type: Alphanumeric
Occurs: 1

Allowable Values: Select one:

R1	American Indian or Alaska Native:
R2	Asian:
R3	Black / African American:
R4	Native Hawaiian or other Pacific Islander:
R5	White.
R9	Other Race:
UNKNOW	Unknown/not specified:

Notes for Abstraction: The data elements, *DHCFP Ethnicity* and *DHCFP Hispanic Indicator*, are required in addition to this data element.

Suggested Data Sources:
Emergency department records
Face sheet
History and physical
Nursing admission assessment
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
• **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliations or community attachment, e.g. any recognized tribal entity in North and South America (including Central America), Native American. • **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. • **Black or African American:** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro, can be used in addition to "Black or African American". • **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. • **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa, e.g., Caucasian, Iranian, White. • **Other Race:** A person having an origin other than what has been listed above. • **Unknown:** Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).	None

Data Element Name: *DHCFP Payer Source*

Collected For: All MassHealth Records

Definition: Source of payment for the services provided to the patient as defined by the Massachusetts DHCFP regulations.

Suggested Data Collection Question: What is the Medicaid Payer Source?

Format:
Length: 3
Type: Alphanumeric
Occurs: 1

Allowable Values:
103 Medicaid (includes MassHealth)
104 Medicaid Managed Care - Primary Care Clinician (PCC) Plan

Notes for Abstraction: None

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Discharge Date*

Collected For: All MassHealth Records

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.

Suggested Data Collection Question: Discharge Date

Format:
Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000 – 9999)

Notes for Abstraction: Because this data element is critical in determining the population for all measures, the abstractor should **not** assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

Suggested Data Sources:
Discharge summary
Face sheet
Nursing discharge notes
Physician orders
Progress notes
Transfer note

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Discharge Status*

Collected For: All MassHealth Records

Definition: The place or setting to which the patient was discharged.

Suggested Data Collection Question: Discharge Status

Format:
Length: 2
Type: Alphanumeric
Occurs: 1

Allowable Values:

01 Discharge to home care or self care (routine discharge)
Usage Note: Includes discharge to home; jail or law enforcement; home on oxygen if DMS only; any other DMS only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.

02 Discharged / transferred to a short to a short term general hospital for inpatient care

03 Discharged / transferred to a skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
Usage Note: Medicare indicates that the patient is discharged / transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61 – Swing Bed. For reporting other discharges / transfers to nursing facilities, see 04 and 64.

04 Discharged / transferred to an intermediate care facility (ICF)
Usage Note: Typically defined at the state level for specifically designated intermediate care facilities. Also used to designate patients that are discharged / transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges / transfers to state designated Assisted Living facilities.

05 Discharged / transferred to another type of health acre institution not defined elsewhere in this code list
Usage Note: Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of health care institutions.

Allowable Values continued:

06	Discharge / transferred to home under care of organized home health service organization in anticipation of covered skilled care Usage Note: Report this code when the patient is discharged / transferred to home with a written plan of care (tailored to the patient's medical needs) for home care services.
07	Left against medical advice or discontinued care
20	Expired

Notes for Abstraction:

The values for *Discharge Status* are taken from the National Uniform Billing Committee (NUBC) manual which is used by billing/HIM to complete the UB-04.

Because this data element is critical in determining the population for many measures, the abstractor should **not** assume that the claim information for discharge status is correct. If the abstractor determines through chart review that the discharge status is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge status through chart review, she/he should default to the discharge status on the claim information.

Suggested Data Sources:

Discharge instruction sheet
Discharge summary
Face sheet
Nursing discharge notes
Physician orders
Progress notes
Social service notes
Transfer record

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix H, Table 2.5 in the Specifications Manual for National Hospital Quality Measures.	None

Data Element Name: *First Name*

Collected For: All Masshealth Records

Definition: The patient's first name.

Suggested Data Collection Question: First Name

Format:
Length: 30
Type: Alphanumeric
Occurs: 1

Allowable Values: Enter the patient's first name.

Notes for Abstraction: None

Suggested Data Sources: Emergency department record
Face sheet
History and physical

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Hispanic Ethnicity (DHCFP)*

Collected For: All MassHealth Records

Definition: Documentation that the patient is of Hispanic Indicator as defined by Massachusetts DHCFP regulations

Suggested Data Collection Question: Hispanic Ethnicity

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:
Y (Yes) Patient is Hispanic/Latino/Spanish.

N (No) Patient is not of Hispanic/Latino/Spanish.

Notes for Abstraction: The data elements, *DHCFP Race* and *DHCFP Ethnicity*, are required in addition to this *Hispanic Indicator* data element.

Suggested Data Sources:
Emergency department records
Face sheet
History and physical
Nursing admission assessment
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
The term "Hispanic" or "Latino" can be used in addition to "Spanish origin" to include a person of Cuban, Puerto Rican, Mexican, Central or South American, or other Spanish culture or origin regardless of race.	None

Data Element Name: *Hospital Bill Number (DHCFP)*

Collected For: All MassHealth Records

Definition: The unique number assigned to each patient's bill that distinguishes the patient and their bill from all others in that institution as defined by Massachusetts DHCFP.

Newborns must have their own billing number separate from that of their mother.

Suggested Data Collection Question: Hospital Bill Number

Format:
Length: 20
Type: Alphanumeric
Occurs: 1

Allowable Values: Values greater than 0 assigned by the system.

Notes for Abstraction: None

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Hospital Patient ID Number*

Collected For: All MassHealth Records

Definition: The identification number used by the Hospital to identify this patient's medical record (Medical Record Number).

Suggested Data Collection Question: Hospital Patient ID (Medical Record)

Format:
Length: 40
Type: Alphanumeric
Occurs: 1

Allowable Values: Up to 40 letters and / or numbers

Notes for Abstraction: None

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Last Name*

Collected For: All MassHealth Records

Definition: The patient's last name.

Suggested Data Collection Question: Last Name

Format:
Length: 60
Type: Alphanumeric
Occurs: 1

Allowable Values: Enter the patient's last name.

Notes for Abstraction: None

Suggested Data Sources: Emergency department record
Face sheet
History and physical

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Postal Code*

Collected For: All MassHealth Records

Definition: The postal code of the patient's residence. For the United States zip codes the hyphen is implied. If the patient is determined to not have a permanent residence, then the patient is considered homeless.

Suggested Data Collection Question: What is the postal code of the patient's residence?

Format:
Length: 9
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid five or nine digit postal code or "HOMELESS" if the patient is determined not to have a permanent residence. If the patient is not a resident of the United States, use "Non-US."

Notes for Abstraction: If the postal code of the patient is unable to be determined from medical record documentation, enter the provider's postal code.

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Provider ID*

Collected For: All MassHealth Records

Definition: The provider's six digit acute care Medicaid provider identifier.

Suggested Data Collection Question: Provider ID

Format:
Length: 6
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid six-digit Medicaid provider ID.

Notes for Abstraction: None

Suggested Data Sources: None

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Provider Name*

Collected For: All MassHealth Records

Definition: The provider name.

Suggested Data Collection Question: Provider Name

Format:
Length: 60
Type: Alphanumeric
Occurs: 1

Allowable Values: Provider name.

Notes for Abstraction: The provider name is the name of the hospital.

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Relievers Administered*

Collected For: CAC-1a

Definition: Documentation that the patient received reliever medication(s) for asthma exacerbation during this hospitalization. Inpatient hospitalization includes the time from arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.

Relievers are medications that relax the bands of muscle surrounding the airways and are used to quickly alleviate bronchoconstriction and prevent exercise-induced bronchospasm.

Suggested Data Collection Question: Did the patient receive a reliever medication(s) during this hospitalization?

Format:

Length:	1
Type:	Alphanumeric
Occurs:	1

Allowable Values:

Y (Yes)	The patient received a reliever medication(s) during this hospitalization.
N (No)	The patient did not receive a reliever medication(s) during this hospitalization or unable to determine from the medical record documentation.

Notes for Abstraction: For the purposes of the CAC measures, inpatient hospitalization includes the time of arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.

For reliever medication(s) administered in the Emergency Department /observation area which was given prior to the inpatient admission, select "Yes."

Suggested Data Sources:
Emergency department record
Medication administration record (MAR)
Nursing flow sheet
Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix C, Table 6.2 in the Specifications Manual for National Hospital Quality Measures for a list of Reliever Medications.	None

Data Element Name: *RID Number*

Collected For: All MassHealth Records

Definition: The patient's MassHealth Recipient ID number.

Suggested Data Collection Question: What is the patient's MassHealth Recipient ID number?

Format:
Length: 10
Type: Alphanumeric
Occurs: 1

Allowable Values:
Any valid Recipient Identification Number (RID) number
Alpha characters must be upper case
No embedded dashes or spaces or special characters

Notes for Abstraction: The abstractor should **not** assume that the claim information for the patient's RID number is correct. If the abstractor determines through chart review that the RID number is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct RID number through chart review, she/he should default to the admission date on the claim information.

Suggested Data Sources:
Emergency department record
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Sample*

Collected For: All MassHealth Records

Definition: Indicates if the data being transmitted for a hospital has been sampled, or represent an entire population for the specified time period.

Suggested Data Collection Question: Does this case represent part of a sample?

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:

Y (Yes)	This data represents part of a sample.
N (No)	The data is not part of a sample; this indicates the hospital is performing 100 percent of the discharges eligible for this topic.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Sex*

Collected For: All MassHealth Records

Definition: The patient's sex.

Suggested Data Collection Question: Sex

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:
M = Male
F = Female
U = Unknown

Notes for Abstraction: None

Suggested Data Sources:
Consultation notes
Emergency department record
Face sheet
History and physical
Nursing admission notes
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Social Security Number*

Collected For: All MassHealth Records

Definition: Social Security Number (SSN) assigned to the patient.

Suggested Data Collection Question: What is the patient's Social Security Number?

Format:
Length: 9 (no dashes)
Type: Alphanumeric
Occurs: 1

Allowable Values:
Any valid SSN number
Alpha characters must be upper case
No embedded dashes or spaces or special characters

Notes for Abstraction: The abstractor should **not** assume that the claim information for the social security number is correct. If the abstractor determines through chart review that the social security number is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct social security number through chart review, she/he should default to the social security on the claim information.

Suggested Data Sources:
Emergency department record
Face sheet
Registration form

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Systemic Corticosteroids Administered*

Collected For: CAC-2a

Definition: Documentation that the patient received oral or intravenous (systemic) corticosteroids for asthma exacerbation during this inpatient hospitalization. Inpatient hospitalization includes the time from arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.

Systemic corticosteroids (oral or intravenous corticosteroids) are recommended as short term or rescue medications to relieve bronchoconstriction rapidly, making them useful in gaining quick initial control of asthma and in treatment of moderate to severe asthma exacerbations.

Suggested Data Collection Question: Did the patient receive oral or intravenous corticosteroids during this hospitalization?

Format:

Length:	1
Type:	Alphanumeric
Occurs:	1

Allowable Values:

Y (Yes)	The patient received oral or intravenous corticosteroids during this hospitalization.
N (No)	The patient did not receive oral or intravenous corticosteroids during this hospitalization or unable to determine from the medical record documentation.

Notes for Abstraction: For the purpose of the CAC measures, inpatient hospitalization includes the time of arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.

For systemic corticosteroids (oral or intravenous) administered in the Emergency Department/observation area which was given prior to the inpatient admission, select “Yes.” None

Suggested Data Sources:
Emergency department records
Medication administration record (MAR)
Nursing flow sheet
Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
Include corticosteroids given: PO/NG/Peg tube: • Any kind of feeding tube, e.g., percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunosotomy, gastrostomy tube • By mouth • Gastric tube • G-tube • Jejunostomy • J-tube • Nasogastric tube • PO • P.O. Intravenous: • Bolus • Infusion • IV • I.V. • IV Piggyback (IVP) Refer to Appendix C, Table 6.3 in the Specifications Manual for National Hospital Quality Measures for a list of oral or intravenous Systemic Corticosteroids.	• Inhalation • Nasal Sprays